STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003154	A. BUILDING: _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HOSPICE SERVICES	931 E 86TH ST STE 208 INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was a state hospice complaint survey. Complaint IN00161464 - Unsubstantiated: Lack of sufficient evidence. Survey Dates: February 2-6, 2015 Facility #: 003154 Medicaid #: 200142900B Surveyor : Nina Koch Heartland Hospice is in compliance with IC 16-25 and 418.52, 418.56, 418.64, and 418.76 as related to this compliant. Census: 467 Quality Review: Joyce Elder, MSN, BSN, RN February 17, 2015	S 000		